Life of a Claim

Indiana Health Coverage Programs
DXC Technology
IHCP Works Seminar October 2020

Agenda

- General Requirements
- System Edits and Audits
- Pricing Methodologies
- Pending/In Process
- Claim Adjustments
- Claim Filing Limit
- Remittance Advice
- Helpful Tools
- Questions

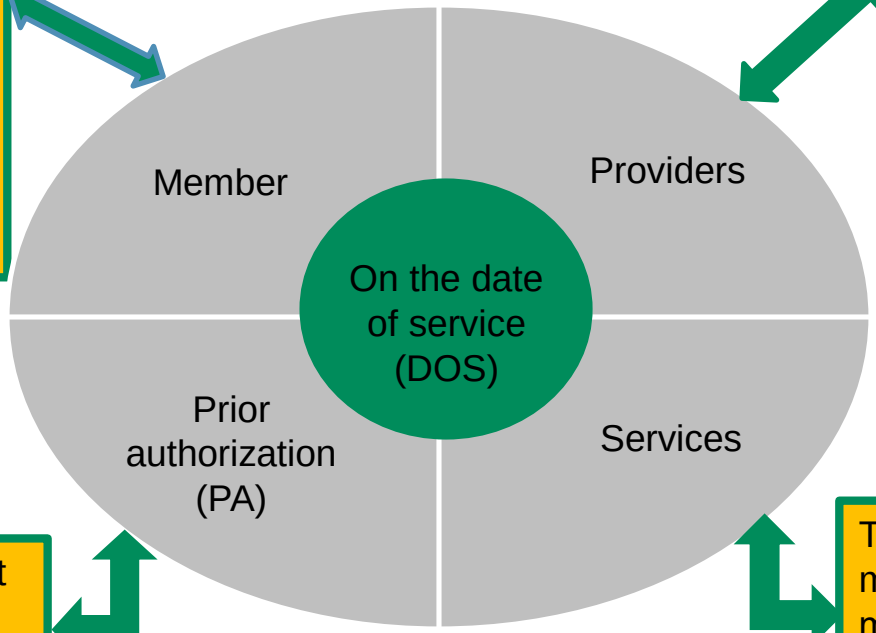
General Requirements

Criteria Required for Medicaid Coverage

The member must be enrolled in Indiana Health Coverage Program. The provider must verify the member's eligibility before rendering services.

The provider must be enrolled in Indiana Medicaid:

- Including out-of-state providers
- Rendering provider must be linked to the group provider National Provider Identifier (NPI) and service location



If the service requires PA, it must be approved before rendering the service.

The service rendered must be covered by the member's Medicaid plan.

Life of a Claim

Indiana Health Coverage Programs (IHCP) claims go through the following stages:

Date of service → Billing for services → Claim processing → Reimbursement

- Member must be enrolled and eligible for the service (benefit plan)
- Services must be covered under the member's Medicaid plan
- Provider must be eligible to render the service (provider contract)
- PA is approved (when applicable)
- Billing/group/and rendering providers must be properly enrolled

Life of a Claim

IHCP claims go through the following stages:

Date of service → **Billing for services** → Claim processing → Reimbursement

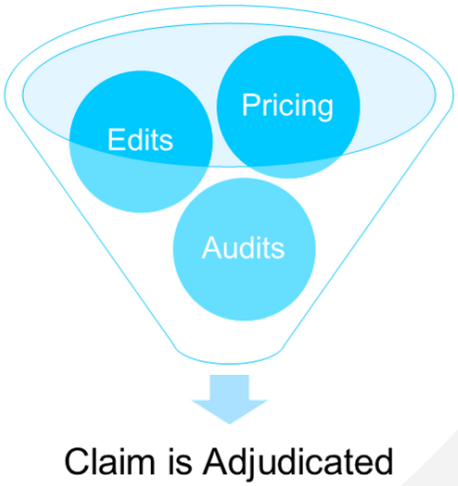
- Use correct claim form and billing codes
- Send claim to the right place:
  - Third Party (when applicable)
  - DXC – if fee-for-service (FFS)
  - MCE – if managed care entity (MCE) member
- Include required documentation (when applicable)
- Bill claim within the timely filing limit

Life of a Claim

IHCP claims go through the following stages:

Date of service → Billing for services → **Claim processing** → Reimbursement

- Claims that pass the initial prescreening are loaded into *Core*MMIS for processing.
  - Paper claims or claims submitted through a clearinghouse that do not pass the prescreening are rejected and returned to the provider with an explanation of why the claim could not be processed.
- Claims will be processed and adjudicated following the Medicaid federal and state policies and regulations.



Life of a Claim

IHCP claims go through the following stages:

Date of service → Billing for services → **Claim processing** → Reimbursement

- Verify that all the required information has been submitted, and information is valid, consistent, and in the right format.
- Claim Status:
  - After the weekly financial cycle is run, a Remittance Advice (RA) is generated to show the provider all their claims adjudicated for that week.

- Determine how to pay or reimburse a benefit.
  - The reimbursement rules define the pricing method by which to pay the service.
- Compare current claim against other paid services on the member's claim history file to ensure:
  - Benefit limitations are not exceeded
  - IHCP does not pay twice for the same service
  - Providers follow appropriate billing practices

Life of a Claim

IHCP claims go through the following stages:

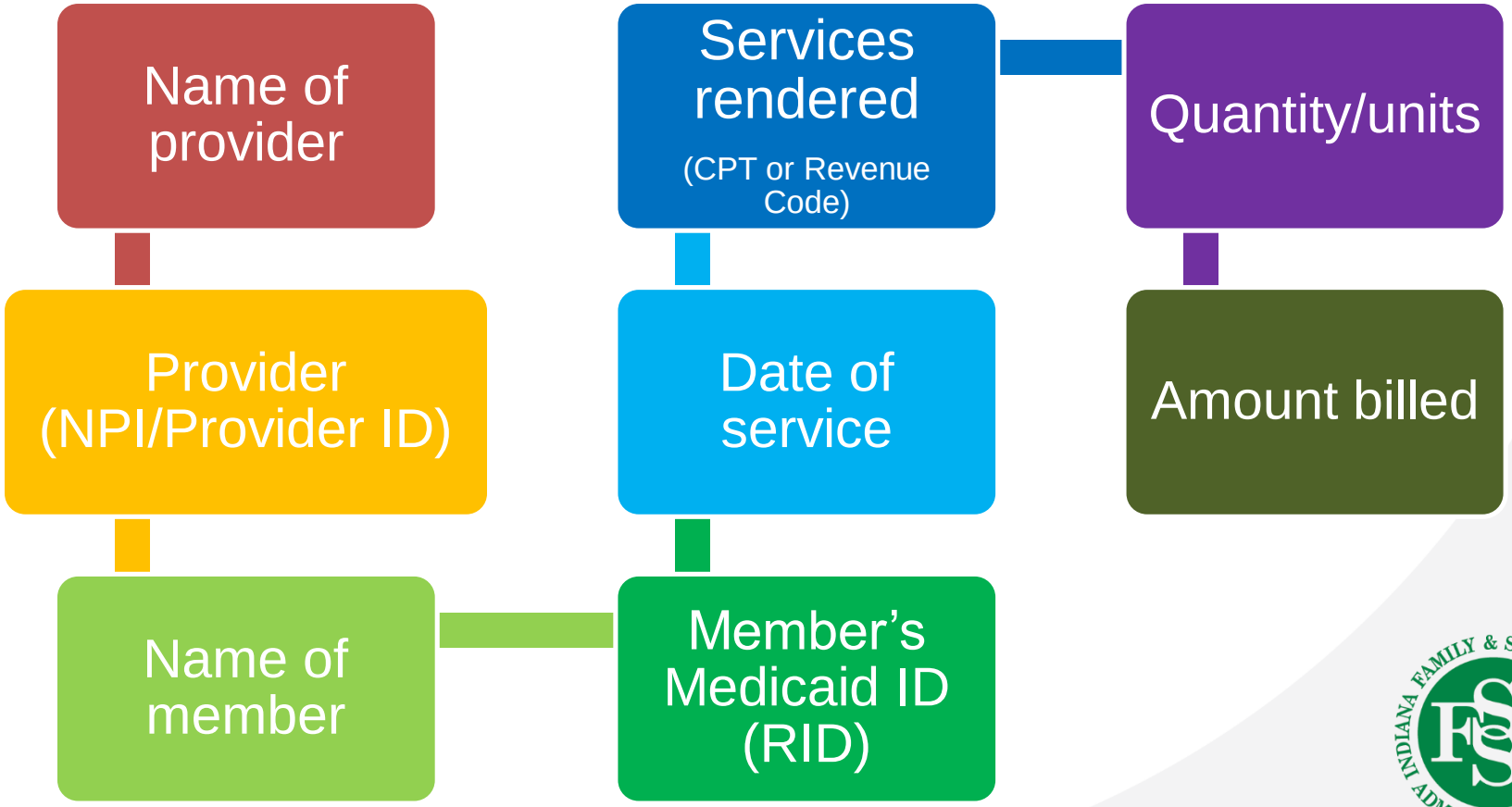
Date of service → Billing for services → Claim processing → **Reimbursement**

When a claim is adjudicated, and is in a paid status, the provider is reimbursed after the weekly financial cycle has processed.

Life of a Claim

Provider submits claims

Claim's required information:



Life of a Claim

What is the National Provider Identifier (NPI)?

- A standard, unique identifier for healthcare providers
- All healthcare providers must bill using their NPI on all claims
- Only atypical, non-healthcare providers can bill using their IHCP Provider ID and qualifier

NPI Crosswalk:

- *Core*MMIS to establish a one-to-one match between the NPI and the service location (Provider ID) where the member was treated
- Three data elements:
  - Billing NPI
  - Billing taxonomy code
  - Billing provider service location ZIP Code+4 on file in *Core*MMIS

If CoreMMIS is not able to establish a one-to-one match, the claim will be denied.

Internal Control Number (ICN)

- IHCP claims are identified, tracked, and controlled using a unique 13-digit Claim ID assigned to each claim called an ICN.
- The ICN identifies when the claim was received, the claim submission method used, and the claim type.
- The ICN identifies the:
  - Region code – Is identified by two digits or the submission media used (paper or electronic) and whether it is a new claim or an adjusted claim

    XX00000000000
  - Year – Is identified by two digits to the calendar year the claim was received

    00XX000000000
  - Julian date – Is identified by three digits to the date the claim was received

    0000XXX000000
  - Batch range – First three digits after the Julian date indicates the type of claim submitted

    0000000XXX000
  - Sequence within a batch – Last three digits identifies the claim's number within each batch

    0000000000XXX

ICN Region Codes (First Two Digits of ICN)

Common region codes:

- 10 Paper claims with no attachments
- 11 Paper claims with attachments
- 20 Electronic claims (837 transaction) with no attachments
- 21 Electronic claims (837 transaction) with attachments
- 22 Internet claims (Provider Healthcare Portal) with no attachments
- 23 Internet claims (Provider Healthcare Portal) with attachments
- 50 Paper single replacement claim, non-check
- 51 Replacement claims, check related
- 55 Mass replacement, institutional provider retroactive rate
- 56 Mass void request or single claim void
- 61 Provider replacement – Electronic with an attachment or claim note
- 62 Provider replacement – Electronic without an attachment or claim note
- 63 Provider-initiated electronic void
- 80 Reprocessed denied claims
- 91 Special batch requiring manual review

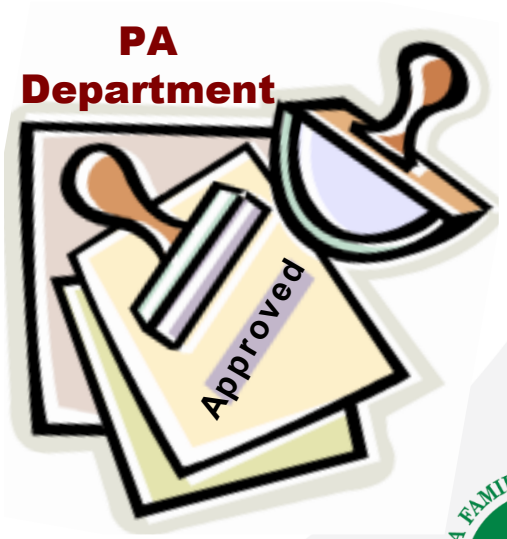
Prior Authorization

According to IHCP regulations, providers must request prior authorization (PA) for certain services:

- To **determine medical necessity,** or
- When **normal limits are exhausted** for certain services

The main purpose of the PA process is to ensure that Indiana Medicaid funding is utilized only for those services that are:

- Medically Necessary
- Appropriate
- Cost Effective



PA is not a guarantee of payment.

Prior Authorization Administrator

- DXC Technology is the PA contractor for nonpharmacy services in the fee-for-service delivery system.
- The DXC PA Unit reviews all PA requests on an individual, case-by-case basis.
- The DXC decision to authorize, modify, or deny a given request is based on medical necessity, appropriateness, and other criteria.

FFS Nonpharmacy	**DXC**	**1-800-269-5720** **1-800-689-2759 (fax)**

Please contact the member's MCE for PA information.

Is the service covered by IHCP Program?

- For the provider to be reimbursed for services rendered, the provider must make sure that the service is covered by the member's benefit plan.
- When a PA is required, the PA must be requested and approved before the service is rendered.
- A provider can verify if a service is covered by the IHCP and/or whether it requires PA by referring to the fee schedules, accessible from the IHCP Fee Schedules page at in.gov/medicaid/providers.

PA belongs to the member, not the provider.

IHCP Fee Schedules

- *Professional Fee Schedule*

  The *Professional Fee Schedule* is updated weekly. This fee schedule includes reimbursement information for providers that bill services using professional claims and dental claims reimbursed under the FFS delivery system.

- *Outpatient Fee Schedule*

  The IHCP publishes the rates for outpatient hospitals and ambulatory surgical centers (ASCs) on the *Outpatient Fee Schedule*. This fee schedule reflects the current IHCP coverage and reimbursement rates for procedure codes billed for the IHCP outpatient services. It is updated monthly to reflect any change to methodology.

Professional Fee Schedule

Procedure Code: Enter at least three characters of the Procedure Code to filter by specific Procedure Code. This search criteria cannot be used in combination with the Procedure Code Range criteria.
Procedure Code Range: Enter a beginning and ending five-character Procedure Code to obtain all Procedure Codes within a range. This search criteria cannot be used in combination with the Procedure Code criteria.
Procedure Code Description: Enter a text string to obtain records containing the entered text in either the short or long Procedure Code Description. This search criteria can be used in combination with the Procedure Code or the Procedure Code Range criteria.

Procedure Code: E0240
Procedure Code Range: to
Procedure Code Description:
Submit

* Code values are described on the Fee Schedule Instructions page.

The *Professional Fee Schedule* is updated weekly.

1

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Category	Service Category Desc	Rate Type	Pricing Method	Pricing Effective Date	Pricing End Date	PA Req'd	Attach Req'd
E0240					DME	Durable Medical	Def	SYSMAN			Y	Y
Min-Max Units					**Fee Schedule Amt:**			**Base Units:**		**Age Min-Max:**		
Procedure Desc:		BATH/SHOWER CHAIR					**CMS Add Date:**		1/1/2004	**CMS Term Date:**		

Outpatient Fee Schedule

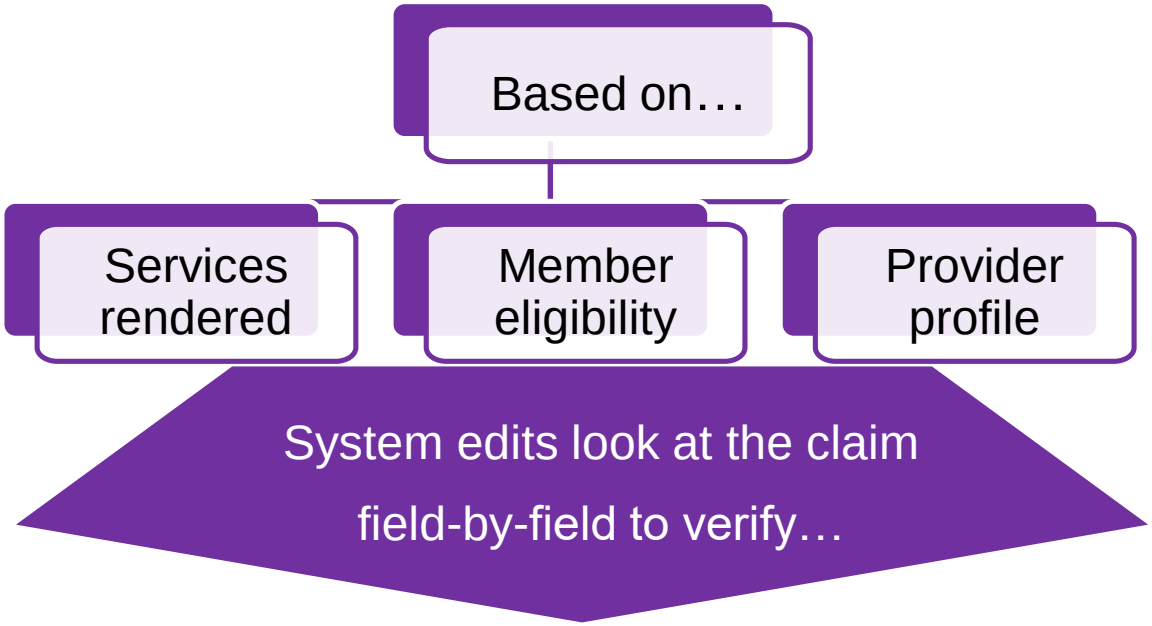
The Outpatient Fee Schedule reflects IHCP coverage and reimbursement policy for individual procedure codes. It is updated regularly to reflect any change in policies. Schedules reflecting the most recent updates are posted for your reference.

- Outpatient Fee Schedule – Effective June 1, 2020
- Outpatient Fee Schedule – Effective May 1, 2020
- Outpatient Fee Schedule – Effective April 1, 2020
- Outpatient Fee Schedule – Effective March 1, 2020
- Outpatient Fee Schedule – Effective February 1, 2020
- Outpatient Fee Schedule – Effective January 1, 2020

The Outpatient Fee Schedule is updated monthly and posted as a Microsoft Excel document.

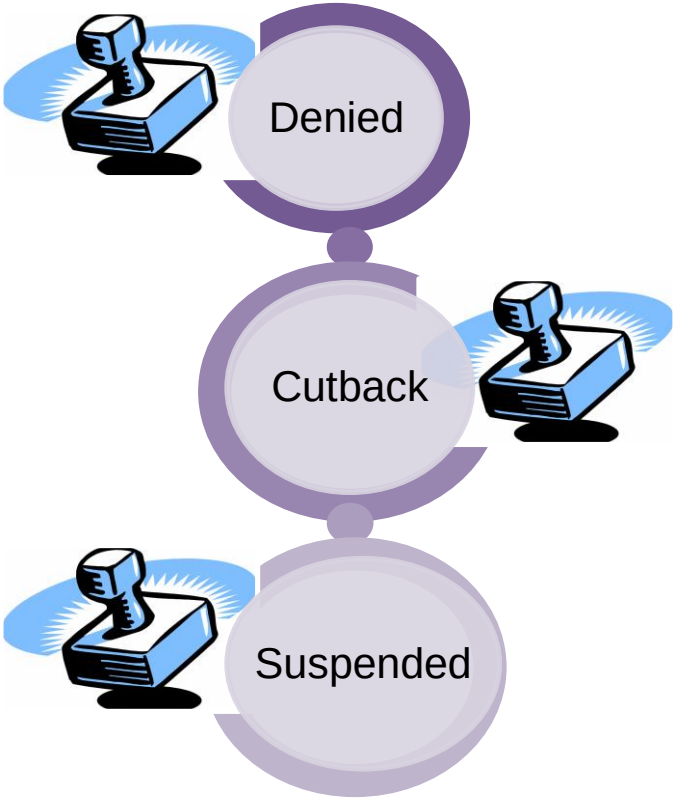
System Edits and Audits

Claim Processed by *Core*MMIS System Edits and Audits



- If all the required information has been submitted
- If there is consistency in the information submitted throughout the claim
- If the information is valid and in the right format
- Are not intended to exclude services

Claim Processed by *Core*MMIS System Edits and Audits



- Edits and audits are designed to monitor and enforce federal and state laws, regulations, and program requirements.
- Claims that fail an edit or audit will do one of the following:
  - Systematically denied
  - Systematically cut back (pays only a portion of the units billed)
  - Suspended - claims are routed to a specific claim location that identifies the type of edit or audit failed

Claim Processed by *Core*MMIS Examples of EOB Codes

EOB Code	Description
0545	Claim Past Filing Limit (PFL)
1004	Rendering Provider Not Enrolled At The Service Location
1010	Rendering Provider Is Not An Eligible Member Of The Billing Group or Group Provider Number
1121	Rendering Provider NPI Submitted Is Reported To Multiple LPIS (Provider ID's)
2505	This Member Is Covered By Private Insurance Which Must Be Billed Prior To Medicaid
3001	Dates Of Service Not On The P.A. Master File
6169	MSRP/Cost Invoice Submitted With The Claim Is Not Acceptable For Adjudication

Claim Processed by *Core*MMIS Examples of Audits EOBS

Audit Code	Description
5000	Possible Duplicate
6060	Speech Therapy Evaluations/1 Per Year
6090	Podiatrist Office Visit Limited to 1 Per 12 month
6113	DME Limited to $2,000 Per Member Per Calendar Year
6235	Prophylaxis and Periodontal Maintenance is Limited to 1 Treatment Every 12 months
6396	Service is Not Payable With Another Service on The Same Date of Service
6900	Psychiatric Services In Excess of 20 Per Rolling Calendar Year

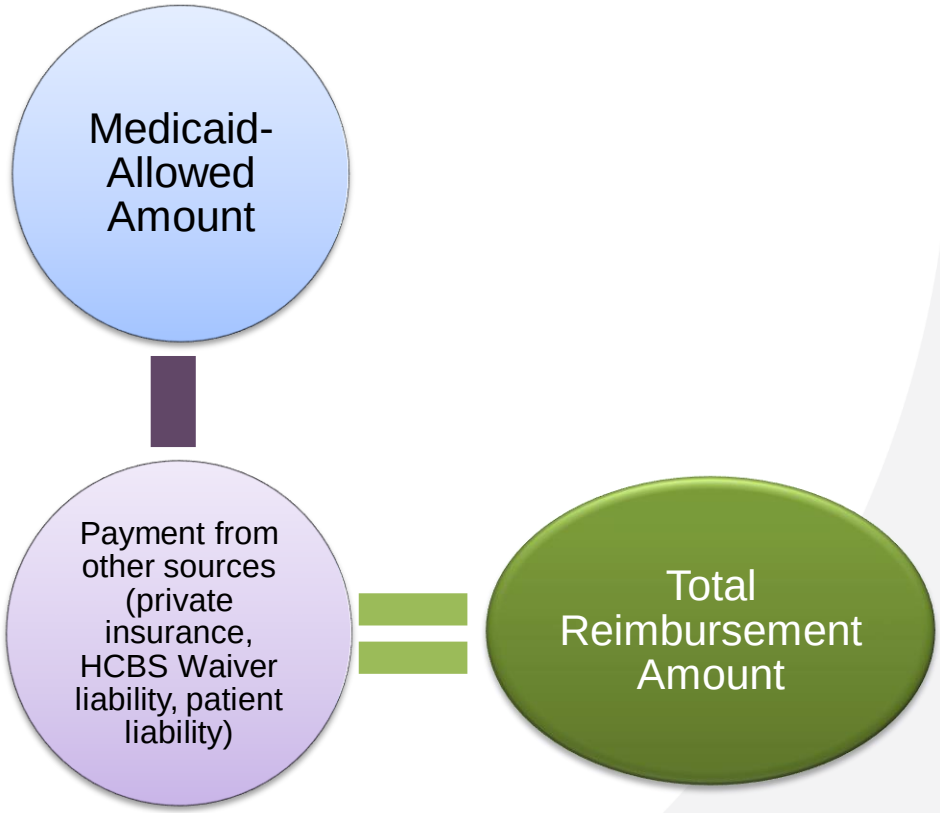
Pricing Methodologies

Claim Processed by *Core*MMIS Pricing Methodology

- After claims have passed the system edits and audits, they are subjected to pricing review.
- *Core*MMIS determines whether or not the claim can be automatically priced, or needs to be suspended for manual pricing.
- This determination is based on:
  - Claim type
  - Procedure-specific pricing indicator
  - Provider specialty
  - Date of service (DOS)

Claim Processed by *Core*MMIS
Pricing Methodology

- The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type, pricing modifiers, and defined pricing methodologies:
  - Based on the claim type, *Core*MMIS directs the claim to the appropriate pricing methodology.
  - If a third-party liability (TPL) amount is present, the system subtracts if applicable primary payment, waiver liability, and patient liability from the IHCP-allowed amount to get the reimbursement amount.



Claim Processed by *Core*MMIS Example of Pricing Methodologies

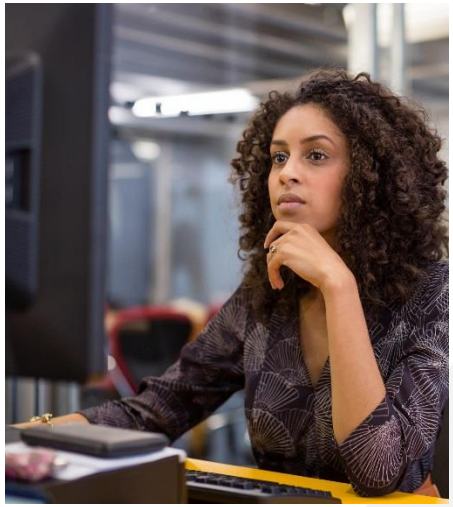
Pricing methodology	Applied to….
Diagnosis-Related Group (DRG)	Inpatient services
Procedure code max fee or revenue code flat rate	Outpatient services
Resource-Based Relative Value Scale (RBRVS)	Physician medical services
Overhead cost rate/staffing cost rate	Home Health services
Max fee	Dental
Lab fee	Lab services
Manual pricing	Durable medical equipment (DME) services
Level of Care (LOC)	LTC, IP Psychiatric, burn, rehab

Pending/In Process

Suspended Claims

Pending/In Process
Claim Adjudicated - Suspended

- When a claim suspends, processing is suspended until the edit or audit causing the failure is manually reviewed and resolved:
  - Adjustments that pend or suspend any edit or audit are routed to the DXC Resolution Unit or the appropriate medical policy department.
  - Prepayment provider review edits are routed to Prepayment Review (PPR) staff within the FSSA Program Integrity team.



Claim Adjustments

Claim Adjustments

- A voided claim results in the full recoupment of the originally paid claim.
- A replacement claim is a paid claim reprocessed with the appropriate modifications.
- There are three types of claim adjustments:
  - Check-related adjustments
  - Non-check-related adjustments
  - Mass adjustments, including mass replacements for retroactive rate adjustments for long-term care facilities and end-of-month adjustments for waiver liability

Claim Adjustments

- Claim Adjustments:
  - Initiated when an excess payment has been made
  - Check-related adjustment is called a refund
  - Provider can refund a partial payment on a claim or the entire payment on a claim

Claim Adjustments

- Claim adjustments initiated by a provider due to an underpayment or overpayment that do not include a refund check from the provider
- Types of non-check-related adjustments:
  - Underpayment adjustment – adjustment was requested because provider was underpaid
  - Overpayment adjustment – request is to adjust an overpayment, the overpaid amount is deducted from future claim payments through an accounts receivable adjustment
  - Full claim overpayment – voided claim creates an accounts receivable to recoup the entire amount of the claim

Claim Adjustments

- Mass adjustments are initiated when a unique set of claims is identified as requiring an adjustment due to new policies or special circumstances.
- Mass adjustments can be used when a system problem caused claims to be paid incorrectly.
- Mass adjustment requests are applied to change a large number of paid claims at one time.

FSSA, Myers and Stauffer, or DXC can initiate a mass adjustment.

Claim Adjustments

- Retroactive rates for long-term care (LTC) facilities are initiated when Myers and Stauffer updates a per diem rate for a specific time frame.
- *Core*MMIS reprocesses all claims submitted by the provider for the DOS affected by the retroactive rate adjustment.
- Retroactive rate adjustments can result in an increase or decrease in payment.

Claim Filing Limit

Claim Filing Limit

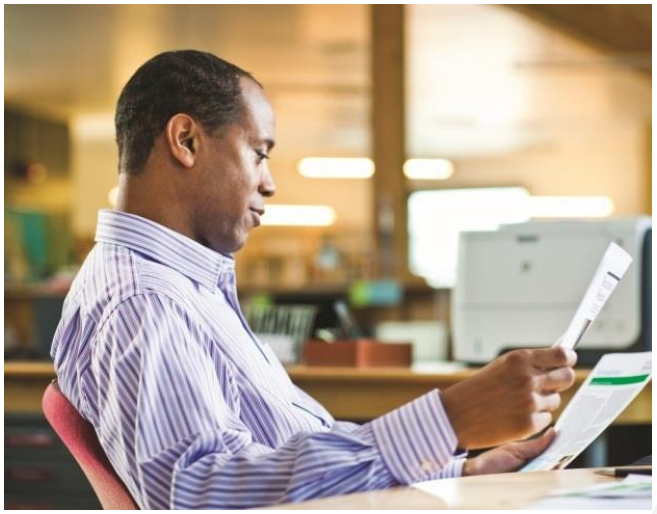
- Effective January 1, 2019, the Indiana Health Coverage Programs (IHCP) mandated a 180-day filing limit for fee-for-service (FFS) claims.
- The 180-day filing limit is effective based on date of service (DOS):
  - Claims for services rendered on or after January 1, 2019, are subject to the 180-day filing limit
  - Inpatient claims, 180-day filing limit is based on member's date of discharge

For more information, please review the *Claim Submission and Processing* module located at in.gov\medicaid\providers.

Remittance Advice

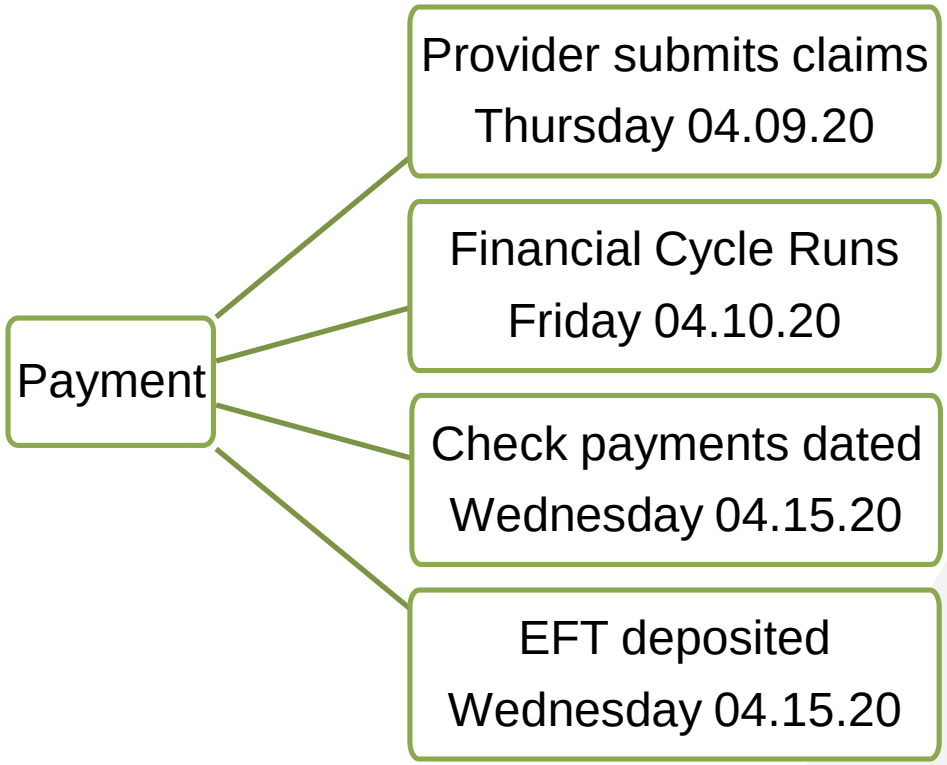
Remittance Advice

- Remittance Advice (RA) statement provides information about claim processing and financial activity:
  - Sorts according to claim type and status (paid, denied, in-process)
- RA provides information about in-process claims, suspended claims, and adjudicated claims that are paid, denied, or adjusted.
- RA statements are available to providers via the Provider Healthcare Portal for downloading and saving.
- Explanation of benefits (EOB) codes are reported to informed providers of corrections for claim resubmissions.



Remittance Advice

- Payments are calculated based on paid claims.
- The IHCP financial cycle runs every Friday.
- Check payments are dated for the Wednesday following the financial cycle.
- Electronic funds transfer (EFT) payments are deposited to the provider's designated bank account each Wednesday following the financial cycle.



Remittance Advice

Search Results

To see payment details, click on the Payment ID link.
To access a copy of the Remittance Advice, select the RA icon. Access to the RA will require Adobe Acrobat Reader.

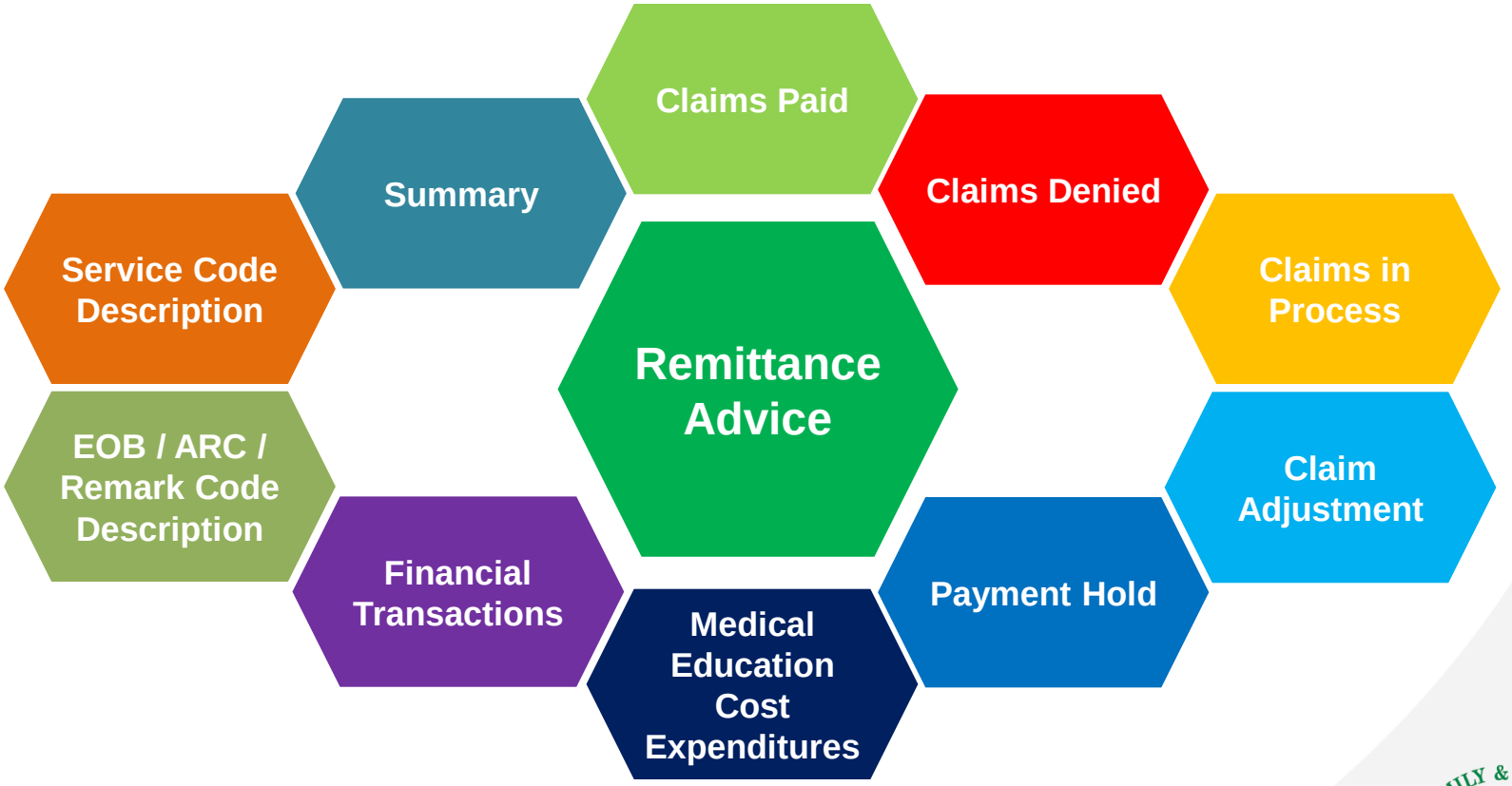
Total Records: 14

Issue Date ▼	Payment Method	Payment ID	Total Paid Amount	RA Copy (PDF)
	Check		$0.00	
	Check		$0.00	
	Check		$0.00	
	EFT		$713,094.24	

1 2

The Remittance Advice opens in a PDF file.

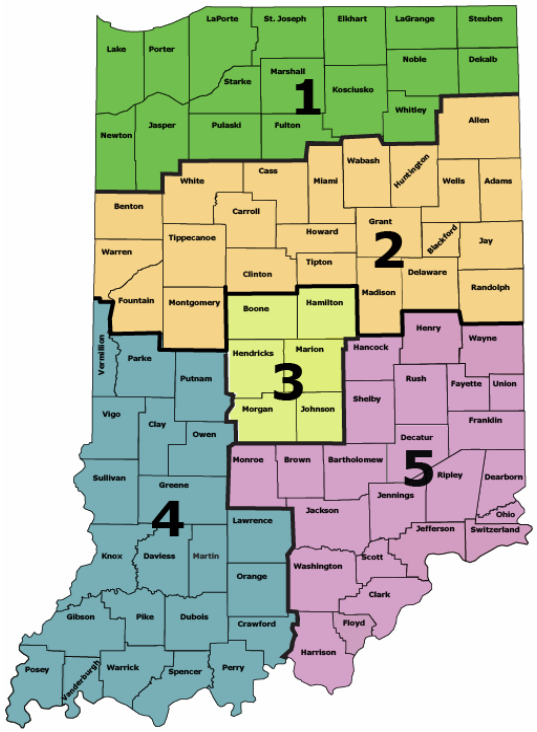
Remittance Advice



Helpful Tools

Helpful Tools

Provider Relations Consultants



Region	Field Consultant	Email	Telephone	Counties Served
1	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Amber Keegan & Emily Redman (interim)	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne

Helpful Tools

IHCP website at in.gov/medicaid/providers:

- IHCP Provider Reference Modules
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal
  - *(After logging in to the Portal, click the **Secure Correspondence** link to submit a request)*

Thank you